Visiting Professors

It has been said that the difference between part-time professors and whole-time professors is that the former are away from their posts for part of the time but that the latter are away the whole time. Be this as it may, it is a fact that university professors are called upon to undertake a great deal of work which is outside their terms of contract and which often takes them away for appreciable periods of time. The universities recognize this, for the work which is done in this way often helps to bring credit to the university and the contacts which are made bring distinguished visitors and may also attract junior staff and research workers of high quality. These commitments are often carried out during vacations and affect the science and medical faculties in particular. But this visiting is not confined to holders of university appointments, and Boards of Governors and Regional Hospital Boards have been generous in granting leave to distinguished consultants who have been called upon to undertake missions abroad. Apart from the local value, these visits form an important link in the ties which exist amongst the Commonwealth countries in particular and with foreign countries and thus also have a national importance. For the visitor they are always an interesting experience but in no sense can they be regarded as a holiday for the work is exacting and the distances which have to be travelled may be very great. New groups of people may be met every few days and the visitor is often strained by the hospitality and by the feeling that he has to appreciate the local circumstances and not make any statements which can be misinterpreted.

In this issue of the *Journal*, Professor Lennon gives an account of one of these visits to the Middle East. The other clinical professors in Bristol have all been called upon to undertake overseas visits during the last few years—Professor Perry to Ceylon, Professor Milnes Walker to Australia, New Zealand and Canada, and Professor Neale to the Caribbean Colonies. In addition, Mr. Eyre-Brook is just back from a tour of the colonies in the Pacific Ocean and Dr. Middlemiss is at the moment on one of his African tours.

The purpose of the visit may be to serve as a visiting teacher for a period, to act as examiner, to give one or more lectures, to hold inspections, to give advice or to collect evidence. Usually the opportunity is taken to combine a number of these functions. In the days before air travel some of these tours would have been quite impossible; flight has made some possible and made them all strenuous. They hold an important place in maintaining the British tradition, in medicine perhaps more than in any other discipline, and we are pleased to see that Bristol is taking its full share in this aspect of our national duty.

VISIT TO IRAQ AND TURKEY

BY

PROFESSOR G. GORDON LENNON

The Ministry of Health had been asked by the Iraq Government to arrange for a Visiting Professor to go for at least three months to Baghdad. The Ministry requested the Royal College of Obstetricians and Gynaecologists to nominate someone to go and I was invited to do so by the President in May 1955. The University of Bristol, to whom I am grateful, agreed to grant me leave of absence for three months. The British Council in Baghdad arranged for me to go to Turkey on my way home.

I arrived in Baghdad on the 19th January, 1956 at 3.30 a.m. I had left London Airport at 8 o'clock the previous morning, and had come by Amsterdam, Dusseldorf, Vienna and Istanbul (K.L.M.). It was very cold on arrival, cold enough for a hot-water bottle in bed, but this was not forthcoming, so dressing-gown, pyjamas and socks had to do instead! On my way from the airport to the hotel I had envied very much an Arab sleeping in the open by the side of a house accompanied by his donkey and boy. They had a roaring fire nearby. December, January, and the beginning of February can be quite cold, with temperatures even down to freezing. In fact, in Baghdad they say that spring starts on 4th February! Three months later when the weather was beginning to get uncomfortably hot I left. Throughout my stay it had been really pleasant, rather like an English summer with very little rain. The only unpleasant feature was an occasional sandstorm.

TEACHING THE STUDENTS

The Royal Hospital in Baghdad is the teaching hospital and is situated in the same grounds as the Medical College. There are British professors in all the subjects except obstetrics and gynaecology, and pathology. The medical students are the cream of the Iraqi educational system. The first 100 scholars in the school-leaving certificate who attain 75 per cent. or more are allowed to study medicine if they desire, and they all desire.

During my visit I gave the students lectures twice a week. I took them on ward rounds and gave instruction in the out-patient department. Clinico-pathological discussions were enjoyed most of all. I found the students very intelligent, extremely keen, and possessed of a much better theoretical knowledge than my own students. They were deficient in practical methods largely, I believe, because no one took any trouble to teach them in a practical manner by the bedside. When I say that I instructed the students in the out-patient department it must not be thought that the patients coming to that department were similar to those in our out-patients. There, patients could attend without having been referred by a doctor. Consequently suitable cases for teaching took a little sorting out. As a result work in out-patients tended to be avoided by the senior members of the unit and was left to the most junior members. One can appreciate, then, that the students were most grateful and intensely interested when I took them for teaching in a side room in the out-patient department and discussed methods of examination with them. Only about one in four of the out-patients who were referred to me would consent to be examined but, this difficulty apart, we enjoyed the sessions there.

PATIENTS

I also operated both on obstetric and gynaecological patients, indeed I covered all aspects of gynaecological operating, and was the first to do Wertheim's operation in Baghdad. The patients walk to the operating table, and nearly all have spinal anaesthesia! The after-care of the operated patient is poor, for example the house surgeons have to do catheterizing if it is necessary. There were many cases of vesico-vaginal fistula, and it was impossible to arrange for suction drainage of the bladder after operation in the management of these cases. All that one could do was to put in a catheter which drained directly into the bed. In spite of this, cases on which I operated were successful: the resilience and powers of recuperation of Iraqi women were truly great!

In the opinion of these people British medical standards and particularly nursing service are supreme. If they have to have a surgical operation many come to England if they can afford to. Consequently I was asked to see many cases in private consultation; but I did few operations outside the Royal Hospital. However, the Iraqis are very keen to improve matters and they have the money to do so.

BOOM AND PROGRESS

About one hundred million pounds a year are obtained from oil royalties, and the Iraq Government has formed a Development Board to sift requests, to make grants, and to arrange for improvement schemes to be carried out. As a result developments are proceeding in all branches. In fact at the moment Baghdad is a boom city; moreover these improvements are not confined to Baghdad—the rest of Iraq sharing them. Thus while I was there, two bridges were being built over the Tigris. This river divides Baghdad in two. These bridges were being built by German contractors with British consultants. In order to prevent floods the River Tigris has been dammed for the first time by mechanical means by the construction of a dam one hundred miles north of Baghdad. This scheme cost fifteen million pounds and I was honoured to be invited to the opening ceremony and saw the overflow water was being diverted for irrigation of large areas of land north of Baghdad. This dam had also been built by German labour with British consulting engineers.

Naturally, medicine is obtaining its share of funds from the Development Board and the most important project at the moment is the building of a new Royal Hospital in Baghdad at a cost of about five million pounds. Other hospitals are being built elsewhere, particularly for the treatment of tuberculosis, and it is possible that there will be a second Medical School at Mosul in northern Iraq. Baghdad and Mosul are connected by railway and there are the most comfortable air-conditioned sleepers for the night journey from one city to the other. Small private hospitals were mushrooming everywhere, probably because the hospital consultants felt a lack of security in their hospital appointments and because they were not allowed to charge fees in the private wing of the Royal Hospital.

HISTORICAL BACKGROUND

One would not go to Iraq without visiting many places famous from Biblical times, such as Babylon and Nimrud. At Nimrud I visited the diggings of Professor Mallowan and there saw the most wonderful marble columns. It was interesting to have coffee with the Professor and his wife (Agatha Christie): for one had a feeling that, during the conversation, she was planning the twist in her next murder story or play!

Travel to such ancient places naturally sets one thinking. Here is a people—one might call them the early birds of the dawn of civilization—who have declined, and had been dominated by the Ottoman Empire for four hundred years until as recently as 1917 when the British liberated them, who have been under British mandate until 1932, and who have since then begun to realize their freedom. They are an immensely intelligent and clever people, who only in the last six years have found themselves

rich due to oil, and one cannot help but sense the prevailing mood of nationalism. The irrigation schemes alone should make the country in years to come much more fertile and able to support a larger population than the five million at present. They have a past from which we have learned, and they have also a past from which they themselves have learned, particularly of oppression; but they have a great future which they are just beginning to appreciate. They are a happy people, easy to get on with, perhaps too frustrating in their administration—a fault not unknown in this country!

GOOD BRITISH INFLUENCE AND POOR SALESMANSHIP

It was valuable to have time to see one's own country from a distance. In this boom city there was healthy British influence in engineering and in culture. But in trade we are lagging. In Britain we are constantly being urged to export, but when one finds that British exports are not backed up by adequate servicing facilities for the goods in question one realizes the deficiencies in our salesmanship. We export thirty million pounds worth of drugs every year, yet an agent in Baghdad (an Iraqi) told me that he wanted to sell more English drugs, but the British firms did not appreciate the intensity of competition, consequently most of the drugs used in Baghdad and Iraq are American, French, Swiss and German. In Mosul a complaint was made to me regarding the delivery time of surgical instruments. The Iraqis said that the delay was caused not by the surgical firms but by the British Crown Agents through whom the goods had to go. I broke my fountain-pen nib and when I went to the agency in a large store in Baghdad I was told that they only had new pens, and no spares. I should have thought there was nothing easier to export than fountain-pen spare parts! Nor had any of the five big shops in Baghdad even heard of British "Biro", whereas every second shop sold American pens of every description. So I had to buy an American indelible pen. Apparently the Iraqi are able to afford the dollars for American motor cars, although Iraq is a sterling area. Many of them told me that they would prefer British cars, but the servicing and spares' supply were very poor compared with American or German facilities. The German Volkswagen is very popular although it is not the car for the rough desert roads.

TURKEY

I visited Turkey on my way home and gave lectures at Ankara and at Istanbul. Both these cities are immensely attractive, Istanbul more so because of its beautiful situation, with the Bosporus, the Golden Horn, and the Sea of Marmora. Indeed, in Istanbul one can stand in Europe and look at Asia, and also stand in Asia and look at Europe. One can sit on the terrace of an hotel on the European side of the Bosporus and view the Selimye Barracks on the Asian side, and ponder its associations with Florence Nightingale. One did not feel so much at home in Turkey as one had in Iraq because the language of the Medical School in Iraq is English, whereas the universal language in Turkey is French. So in Turkey I had to have an interpreter for my lectures, and in an hour's lecture one only delivers half an hour's content. There were other interesting experiences in Istanbul—a Press Conference with its awkward questions on painless child-birth and birth control, and a cocktail party which was held by the representative of the British Council in honour of a visiting radiotherapeutist from England and myself. To this cocktail party the Russian Consul had brought a book on "*L'analgésie de l'enfantement*" for me and a book on cancer treatment for the radiotherapeutist. This was the first time I had met Russians in my travels.

Despite inflation the Turks are planning new hospitals and I saw in Ankara a new hospital about to be opened which had been built by the Government as a hospital for private patients because the doctors in the Health Service had no private beds anywhere in Ankara. At this hospital the Government had built a most interesting Nurses' Training School, complete with gymnasium for the nurses, library, and the other usual facilities. This was co-operation between private enterprise and National

Service which interested me very much. In Ankara is one of the best hospitals for obstetrics and gynaecology I have ever seen. The only unsatisfactory feature of the hospital was a radiotherapy machine made by an English firm. The apparatus had never worked since its installation three years previously! Small wonder that the other hospitals being built in Ankara and Istanbul were being equipped with German material.

THE FUTURE

It is always difficult to assess what one has accomplished on such a trip. One makes many friends, but I also hope and believe that my talks to the students on maternity services, maternal mortality rate and infant mortality rate, may have fallen on fertile ground, and will help the future of the services in Iraq. I sent a report to the Minister of Health which he had asked me for. In it I stressed Iraq's need for an adequate nursing service and the proper training of midwives. Only about 5 per cent. of confinements in Iraq is institutional, and therefore pre-natal care should be all the more intense. But unfortunately at the moment there is little or no pre-natal care. There is a wonderful opportunity for a few British midwives and other specialists to go to Iraq and undertake the building-up of such services, but those who go must look upon the venture as a long-term project and a career, and must dedicate themselves to it. The World Health Organization is attempting to do this, but I feel the task would be both better done and more appreciated through separate individual appointments. Britain's future now depends upon such cultural exchanges: the opportunity exists, and if we in Britain do not accept such a challenge then others will. President Eisenhower has already indicated that the Americans are ready.

STUDENT APPRENTICESHIP TO GENERAL PRACTITIONERS

BY

W. M. CAPPER, F.R.C.S.

Clinical Dean, University of Bristol

Since 1953 there have been two major changes in the clinical training of students in this University. One is in the first three months and the second in the last three months of the course. The first is that for a week during the pre-clinical course every student is attached to a ward to do the ordinary work of a nurse. This means that every student has first-hand experience in the general nursing care of the patient in the wards. The other major change has been that an opportunity is now given to every student during the last three months of his training to be attached to a general practitioner. This was started in 1954 and has been carried out every year since.

In 1954, 36 students took part in the scheme; in 1955 there were 30, and in 1956, 28. Students were attached to 6 country practices and 18 town practices and the list of practitioners asked to participate has been drawn up every year by a committee appointed for the purpose. Briefly the scheme consists of attaching one or two students to a general practitioner in or near Bristol for a period of a fortnight during the months of March and April before the finals in June. The student usually reports to the practitioner for the morning surgery and goes with him on his rounds during the day, seeing such cases as the practitioner decides and attending the evening surgery. He is also on call for any night work. In most cases he attends the doctor throughout the day and has an opportunity of discussing the patients with him and of seeing the general run of practice. In some cases the student lives with the doctor and in others he finds his own lodgings close to the practitioner's surgery.

As far as possible students are set free from any attendances at the University during this time and are able to attend the practitioner throughout the day.

STUDENTS' APPRECIATION

From the point of view of the student the scheme has met with very considerable appreciation; almost without exception they report that they have thoroughly enjoyed the experience and have enlarged their knowledge considerably. They have been most hospitably entertained by the practitioners. Many students have stated how valuable it has been in getting experience in the doctor-patient relationship, the general approach to patients and the treatment of the common ailments.

PRACTITIONERS' REACTIONS

The general practitioners for the most part seem to be quite impressed with the knowledge, ability, and keenness of the students. At the end of their time the practitioners send in a report of the students' work which is filed with the students' records.

The reaction to the scheme by practitioners has been variable.

One writes:

"I found the experience most stimulating and interesting. My patients without exception welcomed us. Many of the chronic sick and the neurotics delighted in displaying their troubles to a new doctor. . . . I would be grateful to participate on any future occasion."

Another writes:

"Frankly I doubt if the scheme run as at present is worthwhile. These students come too near the final M.B. to get any benefit at all. Manifestly we cannot show them much but if they are to have not only the looming final but minor day-to-day tutorials to worry about, I think they would be better not to come at all. In my own two examples this year, in hardly any case did either student see the patient twice—the exception being a maternity case we visited a few times. Such an impression of general practice is ridiculous—the whole point is we are dealing with people we see often. I think they should come for at least two weeks. and have no other duties at all during the time they are with us."

And another:

"Both students were most keen on the work, neither missed a single item of surgery or visiting work whilst here; each hung to my tail the whole time. I found both very knowledgeable and most helpful whenever I sought advice as to the kind of treatment this or that case here would receive if treated in hospital. My patients found —— the more forthcoming and sympathetic but all seemed to have liked both of them. I had asked for no opinion at all but have had it given freely at my subsequent interviews with many of them. My opinion is that they are extremely keen young folk, already well versed in general medical knowledge, and both should make good doctors. Both seemed, in quite different ways, to be sound young folk and I feel that if they are a fair sample of the kind of people the University are turning into doctors there need be no anxiety for the future class of doctors."

A fourth makes a suggestion:

"The scheme at present is that a medical student in his final year is apprenticed to a general practitioner for a period of two weeks. This I suggest is far too late in his career. By that time he is already conditioned by several years of hospital work and regards a 'patient' from the hospital angle which is quite different from seeing them in a G.P.'s surgery or in the background of their own homes. Also, this is rather an anxious time for him because he is far too preoccupied in mind about his forthcoming examinations to derive the full benefit from his experience. I feel it would be much better to learn about general practice at the beginning of his clinical studies. As he signs on for his various clinics he would at the same time be apprenticed to a G.P. for the remainder of his medical training. The details of this apprenticeship would provide a fruitful subject for discussion."

The general impression from many letters from practitioners is that they welcomed the scheme but thought that it was rather late in the career of the students to see general practice; also that the students should be absolutely free from all University commitments during the fortnight of apprenticeship.

UNIVERSITY'S GRATITUDE

From the University point of view the scheme has been satisfactory. It is of course, impossible in the present medical curriculum to free students completely from all University commitments. Indeed, the present curriculum is so heavily loaded with so many and so diverse details that it is difficult to fit in anything extra at all.

There is no doubt that the students have gained by this scheme and we should like to thank all those practitioners who have taken part and who have given freely of their time and energy, and often hospitality, to enable the students to see the inner side of general practice. Without exception there has been whole-hearted co-operation in the scheme, and we are extremely grateful for all that has been done. Whether future changes will be possible along the lines suggested, is not yet determined.

MODERN TRENDS IN PUBLIC HEALTH*

BY

R. C. WOFINDEN, M.D., D.P.H.,

M.O.H., City and County of Bristol

I am deeply honoured to be asked to address this learned society. I do so with some trepidation for I find that we Medical Officers of Health have appeared before you at very infrequent intervals. Indeed, the last occasion was forty-seven years ago and the first, and only other occasion, was in 1900 when Dr. D. S. Davies gave his Presidential Address entitled "Some Modern Aspects of Preventive Medicine". You will see that my title "Modern Trends in Public Health" is almost the same but progress in the past half-century has been so great and so rapid that I cannot hope to do more than touch on some of the more recent developments in the public health field.

GENERAL PRACTITIONER–PUBLIC HEALTH–HOSPITAL RELATIONSHIPS UNDER THE NATIONAL HEALTH SERVICE ACT, 1946.

When the provisions of the National Health Service Act were first read by M.O's.H., and Local Authority representatives they occasioned great despondency. The Local Authorities cleaned up the environment in the "Sanitary Era" and then developed first-class facilities for personal health through their maternity and child welfare and school health services. After providing infectious disease hospitals and sanatoria they were on the way to building up a sound general hospital service and there was a chance for the real integration of prevention, treatment and after-care. Indeed, the 1930's during which much of this progress was made has often been referred to as "the Augustan age of public health". Then, in a short Act of Parliament containing no more than eighty sections, the carefully bonded cords of integration and co-ordination were cut asunder. The difficulties, indeed the folly, of splitting the health service into the three divisions of hospitals, general practice and public health, are well known to us all. Looking back over the past eight years it is astonishing that developments have proceeded so smoothly and the degree of co-ordination achieved, despite the administrative boundary lines speaks highly for the goodwill and co-operation on the part of all the workers in the different branches. It is indeed something to be thankful for that not all the boundary lines have become frontiers.

If all branches had been placed under one administration, however, I have no doubt that more rapid and greater progress could have been made. A much more closely integrated service would have been produced and planning could have been on rational lines unencumbered by the eternal battle of rates versus taxes. I would remind you that in 1955–56 the gross expenditure of the Exchequer on the National Health Service was estimated at £477×10^6. Sixty four per cent. of this money was to be spent on hospital and specialist services, 28 per cent. on general practitioner services and only 4 per cent. on Local Health Authority Services.

Naturally, when we are ill we all want to have the best possible treatment and for some conditions this can only be obtained in hospital. But those of us who work in the public health services would like to see, if we are going to have a fixed overall budget, some redeployment of expenditure with more spent in trying to lessen the need for expensive hospital treatment. I am sure that general practitioners too are beginning to realize that their future vested interest lies in prevention. There are indications that many conditions treated in hospital today might with economy be

*An abridged version of an address to the Bristol Medico-Chirurgical Society given on Wednesday 14th March, 1956.

catered for in the home. This will only be done by developing a first-class partnership between the practitioner and the local health authority field workers—the health visitor, the midwife, the home nurse and home help and with the help of the hospital consultant or specialist. Let me give one illustration. In 1953 nearly two-thirds of mothers in this country were confined (and many of them were normal cases) in hospital where costs are in the region of £20 a week. Even with midwives, a general practitioner, a flying squad if need be, and some home help assistance, a home confinement is estimated to cost only about one-third of this amount. To look at the same problem in another way, a distinguished hospital administrator estimated that one maternity bed less will release enough money for three mental hospital beds, four mental deficiency beds or three geriatric beds.

In the field of sick children too there are signs appearing of the flight from the hospital. We read of hospital units being established to house mother as well as the sick baby in order to avoid psychological damage to the child by separation from its mother. A Dutchman has gone so far as to say that it is "psychological murder" to nurse sick children in hospital. Not all of us would subscribe wholly to the Dutchman's thesis but apart from psychological considerations the Medical Officer of Health for Rotherham has shown the possible life-saving effect of nursing sick children at home instead of in hospital and I have no doubt we shall see further developments in this field.

No doubt, too, you will have seen recent reports of some 400 hernia cases sent home from hospital almost immediately after operation only a very small proportion of which needed readmission.

Developments such as these might not save a lot of money directly but they would shorten waiting lists and get people fitter more quickly. It would mean the further development of the Local Health Authority home services but this would be far less costly than building, equipping and staffing more hospital beds.

Hospitals are very necessary—but on psychological grounds they should be places to avoid entering as far as possible and places to get out of as soon as possible.

You will see from what I have said that I believe we need to orientate our health services around the home rather than have them hospital centred. The home, with its family unit, is a more natural setting for the treatment of sickness than the feverish and highly artificial atmosphere of the hospital. Moreover, it is the common meeting-ground of prevention and treatment. Most people spend at least two-thirds of their daily lives in and around the home—their health influenced by the people, the environment and the social circumstances surrounding them. This is the setting so well known to the general practitioner and health visitor. Here are generated many of the stresses and strains of everyday life which affect the health of the individual. I believe it is one of the duties of the public health services to give every assistance to the general practitioner in performing his work in the home.

Moreover, strengthened home care services and closer co-operation with the hospital consultant are needed for the after-care or rehabilitation of those discharged from hospitals. Professor Ferguson of Glasgow has shown by a follow-up of cases sent home from a medical ward how few of those discharged had been able to take their place as healthy members of society. Professor Querido of Amsterdam has produced similar findings for a whole range of patients discharged "cured" or "relieved" from hospital. Hospitals unfortunately often have to treat the end-results of pathological processes but we should do all we can to render what necessarily must often be patchwork as effective as possible. Here and there we see the beginnings of a more efficient after-care service—notably in Cardiff where specialized health visitors assist the general practitioner in the hospital after-care of diabetics, and peptic ulcer and asthma cases.

MODERN EPIDEMIOLOGY

I suppose there are many people who still regard epidemiology as the study of the origins, development and distribution of epidemic diseases. Undoubtedly, when

epidemics of pestilential disease were prevalent their systematic study in the mass was the preoccupation of our epidemiologists who, for the most part, were to be found in public health departments.

Today, most of the epidemic infectious diseases are under control, and epidemiology is concerned increasingly with the study of the origins and causes of non-infective conditions; indeed, with the whole range of human disease. It has been defined as the "science of the mass phenomena of disease and disability". Morris has pointed out that "The clinician deals with cases. The epidemiologist deals with cases in their population. He may start with a population and seek out the cases in it; or start with cases and refer them back to the population, or what can be taken to represent a population." We are beginning to realize that many diseases may have their origins not so much in the physical environment as in our social milieu—i.e., in our way of life, within the home, or in the community or at our work. As our social habits and customs change with time so does the pattern of disease. Undoubtedly, also, one must try to take into account constitutional factors in any such aetiological studies.

Morris has described seven different ways of looking at epidemiological data:

(*a*) The historical approach—the study of diseases over a period of time to see whether they are declining or increasing and he instances the current trend of mortality in middle age in Western countries.

(*b*) Community diagnosis—the identification of vulnerable groups in the community, e.g. in regard to foetal and infant loss.

(*c*) To estimate the individual's chances of suffering or not suffering from certain diseases or disabilities and he shows how this can be done through a life-table approach.

(*d*) Operational research—the study of how community health and welfare services are working. My pilot investigation of multiplicity of home visiting is a good example of this approach, also my old-age studies.

(*e*) For completing the clinical picture. Morris goes on to show that statistics of "coronary thrombosis" based on hospital returns alone give only about a half of the total cases which probably occur—the other half being dealt with by general practitioners or the coroner.

(*f*) The Identification of Syndromes—As Ryle has shown from mortality statistics for "peptic ulcer" there are probably two different conditions to be studied with probable different causes.

(*g*) Clues to Causes—e.g. by a study of mortality from certain diseases in groups of the population subjected to varying work loads; the possible relationship of bronchitis and other lung diseases with urbanization; the possible relationship between smoking and lung cancer and so on.

Much of the time of the personnel working in public health departments is spent in working in special groups in the population—the pre-school child, the school child, the aged, or the handicapped and they are in an excellent position to carry out such epidemiological studies. Some health departments are in fact carrying out such studies either alone or on behalf of central research bodies. Undoubtedly, at present, these aetiological studies can only give broad indications of where to look further for causes without pin-pointing specific aetiological factors. Moreover, to be really effective these studies must be based on accurate and comprehensive diagnostic data and this often can only be obtained from general medical practitioners or hospital specialists.

Hitherto, only certain of the infectious or industrial diseases have been compulsorily notifiable. If we are to make further epidemiological progress it will be necessary to extend and improve the technique of notification. I am not suggesting that all disease processes should be compulsorily notifiable but with thought and careful planning I have little doubt that a good case could be made for the notification of certain of the killing diseases which are showing an increasing incidence.

There is already a precedent, for the Ministry have approved the plans of one Local Health Authority to make coronary artery disease a notifiable condition.

THE PREVENTION OF MENTAL ILL HEALTH

I believe that another big public health task that we have to tackle in the next few decades is to reduce, if we can, the burden of mental ill health. Today we have a crisis on our hands with nearly half our hospital beds filled with cases of mental disorder and mental deficiency and with a chronic and worsening shortage of mental nurses. The Government and the profession are pre-occupied in how to continue bolstering up this salvage work. I believe the time has come when we must direct our thoughts to the possibilities of preventing mental ill health at least that portion of it concerned with emotional mal-adjustment.

Local Health Authorities have been assigned this task under Section 28 of the National Health Service Act under which we have the duty to prevent "illness" and "illness" includes "mental illness". Ferguson Roger has written:

> "mental and neurotic illnesses are so prevalent that we are never likely to solve the vast problem which they present by increasing our resources for treatment."

Obviously no local authority can hope to fulfil this task without the co-operation of the hospital consultant and specialist and the general practitioner. But first it will be necessary to fight a long and hard battle of educating lay persons in positions of authority and the general public for we shall be able to move no faster than public opinion allows. At present, as soon as one starts talking about providing preventive mental health services, fears, prejudices and feelings of guilt appear to be aroused.

There was a time when it was hoped that the child guidance clinic, by giving guidance at an early stage to parents of maladjusted children, would prevent much adult mental ill-health. I cannot judge for myself how far the child guidance clinic has succeeded in this task but I would like to quote Elizabeth Irvine to you—a lady of considerable personal experience in this field:

> "It became gradually clear that, however much child guidance facilities are multiplied, however great the extension of early treatment, even this expanded therapeutic service would touch only the fringe of the mental hygiene problem. The only possible answer is to develop a true preventive service."

How, then, is such a service, or the beginnings of such a service to be provided?

I believe, with Elizabeth Irvine, that it is necessary to give "skilled and sensitive first aid at the earliest opportunity" and that this can be most readily achieved by the Maternity and Child Welfare Departments and the general practitioners. "There is only one service which has routine contact with nearly all mothers and babies—the Maternity and Child Welfare service, and the professional groups to whom the mother brings her problems are the medical officers and the health visitors in this service, together with the general practitioners." To enable public health doctors and nurses to do this job would necessitate some modification of existing training programmes; it would also mean training and employing more of them to facilitate smaller case loads. Much can be done, however, as is being shown in the London County Council, by in-service training of existing staff. Such schemes as I suggest are being tried in other countries, e.g. in the Vancouver Health Department where they are referred to as "anticipatory guidance" in child health centres.

We have made a small start in this city by the employment of two psychiatric social workers who are working in the Maternity and Child Welfare department and it is my earnest hope that from these small beginnings we shall go on to develop a service of real preventive value.

HEALTH CENTRES

I have referred to the disadvantages of split administration in the health services. Undoubtedly the architects of the National Health Service must have hoped that "Humpty Dumpty" could be put together again by housing together in health centres the workers in the preventive and therapeutic fields. I could not let this occasion pass

without some reference to the William Budd Health Centre in Bristol—the first centre to be built by a Local Health Authority. It has been open now for three and a half years and in my opinion, and in the opinion of all who work there and of the hundreds of visitors (many of them from overseas) who have studied it, the Centre has attained considerable success. It is a pity that some of its greatest critics have never visited the Centre. It is one of the few places I know where professional and lay staff from all three branches of the health service are working together under one roof. Misunderstandings between general practitioners and public health workers have been removed and all are working together as a team with the aim of improving the health and welfare of the people living in the locality. It is an experimental venture and since its inception additional new aids have been provided for the general medical practitioner—e.g. the nutrition clinics and the services of a psychiatric social worker.

It was at the William Budd Health Centre that we made our first (and very successful) attempt to streamline the City's ante-natal and post-natal services. Many general practitioners are now seeing their patients in the City's clinics in association with the domicilary midwives, and with the help of one of the Board's obstetric consultants. They have been relieved of many of their non-productive tasks and the Local Authority has been able to continue its health educational activities amongst a very important group of the population. The fact that so many expectant mothers can now receive all, or almost all, their care in one place is a step in the right direction. No one would claim that we have achieved a fully streamlined service but I know that many other towns would welcome a similar organization.

Some of us would like to see radiological and clinical pathology facilities provided for *all* the doctors working in the centre area. Radiological and pathology consultants would need to supervise the service. One of the greatest advantages of such a scheme would be the *ready* accessibility of the consultants to the general practitioners. I know that it is now possible for general practitioners to refer cases for investigation to hospital radiology and pathology departments and to discuss their cases with the consultant. But many general practitioners are far removed from, and haven't the time to visit, hospitals; moreover, there would be the essential difference in a health centre that the practitioner was working on his "home ground".

The William Budd Centre has been criticized on the grounds of its expense. It is serving a population of nearly 20,000 for Local Health Authority maternity and child welfare and school health purposes, and there are some 12,000 patients at risk on the doctors' lists. I think you might agree therefore that a lot of preventive and therapeutic service is being provided for the £10,000 per annum it costs to run.

There have been a number of reports in recent years criticizing general medical practice in England and Wales and stressing the need to up-grade it. To my mind the provision of health centres, where the doctor can be relieved of non-productive tasks and where he can be given the tools to do this job, would be the ideal way of doing it. If I am right in saying that the vested interest of the general practitioner is no longer in disease but in health we must give him the opportunity to teach health. Each consultation provides such an opportunity but it cannot be grasped unless we provide him with the necessary time in which to do it. Such time can be found in health centres. The alternative seems to me to be the training and employment of many more doctors so that case loads could be reduced.

PROBLEM FAMILIES

In recent years health departments have shown an increasing interest in the reclamation of problem families. Their characteristics are well-known to you—the squalor of the home, the instability of marriage and family relationships, the repeated running into debt, child neglect, alcoholism, and the discord with their neighbours and the community in which they live.

They have been thrown into relief whenever they have been rehoused from slum quarters on the new housing estates where they fall short of prevailing social standards.

Undoubtedly each problem family presents a unique family problem which has to be tackled as such. But they have certain characteristics in common—mental subnormality coupled with instability of character of one or both parents. Many appear to be ineducable by any present-day methods. They are a problem to the many statutory and voluntary workers from whom they receive help. General medical practitioners, hospital specialists and public health doctors and nurses know how difficult it is to get the parents to co-operate in treatment of either themselves or their children.

Until comparatively recently it was common practice to prosecute the parents for child neglect (the penalty for which was usually a prison sentence) and to take the children into official care. Now, however, public opinion is no longer so hostile and there seems to be a genuine desire to help them back to normal life. Partly from economic necessity (i.e. to reduce the expense of looking after children in children's homes) and partly from the powerful influence of Bowlby's report on "Maternal Care and Mental Health" there is now a widespread acceptance of the view that whenever possible the family should be kept together as a unit.

In the first place, some attempt is being made to reduce the number of visitors to their homes; this helps to cut out the often fragmentary and sometimes conflicting advice which was given previously. Co-ordination is being achieved through case conferences at which it is usual for representatives of statutory and voluntary organizations working in the area to be present. At such meetings their problems can be discussed in detail, responsibility for future care assigned to one worker and all other agencies learn which worker must be kept informed. Often the responsible home worker is the health visitor, sometimes the children's officer or the welfare officer of the Welfare Department. At such conferences I have been impressed repeatedly by the variety of health problems—particularly in the mental sphere but also of physical ill health—which become manifest. There is undoubtedly a need to spot these problems at a much earlier stage and to try to put them right.

Family Service Units are doing a good job of work on their behalf; sometimes their workers are more acceptable to the problem family than the statutory workers but not always so. The keynote of their work is to forge friendly relationships and to help the family to build up self-reliance and independence. The secret of much of their success lies in the small case loads they accept—thus ensuring that sufficient time is spent with each family.

You must all have been impressed with the poor health of many of these mothers who so often bear a large number of children very rapidly. For them a spell of three months at a recuperation centre such as Brentwood is often invaluable, not only to allow the mother to recoup her health but also to let her regain her self-respect and to receive training in mothercraft and housewifery. A few Local Authorities have their own recuperation centres and we hope in due course to provide one in Bristol.

Many of us believe that these families ought to be spread thinly throughout the community in reconditioned properties rather than concentrating them on new housing estates. This is what we are doing in Bristol and we are finding that in such units and with intensive family case work one can often prevent the family from breaking up or reconstitute the family which has already broken up.

It is clear that our efforts on their behalf are still patchy and relatively uncoordinated. There is a great need to find out more about the root cause of problem families and I feel sure that there is need for much help from our colleagues who specialize in mental health.

FUTURE DEVELOPMENTS IN ENVIRONMENTAL HEALTH

Although the nineteenth century was referred to, in the public health world, as the environmental or "sanitary era" we should realize that notable advances have been made in the improvement of our environment in the last fifty years, particularly in housing and slum clearance. But much remains to be done, for new environmental problems are constantly arising out of our changing mode of life and work. We have

scarce begun to tackle the problem of providing a satisfactory working environment for many of our factory workers and for our shop and office workers. Rapid developments are taking place in the food industry whereby more and more of our natural foodstuffs are being processed in one way or another—"sophisticated" is the modern word—in order to render them more attractive to the customer. This sophistication, involving as it does, chemical additions to foods, or their subjection to various rays may not be entirely free from risk and at present goes on almost unregulated. I must confine myself to only one development in the environmental health services which we shall see well under way during the coming decade—the provision of clean air.

ATMOSPHERIC POLLUTION

For many years The Smoke Abatement Society waged a continuous but unsuccessful battle for the abatement of atmospheric pollution. The evils of pollution such as waste of fuel, damage to agriculture, buildings and clothing and to health have been realized for a long time. In recent years two disasters to the public health have arisen from atmospheric pollution coupled with abnormal weather conditions—the Meuse Valley episode in 1930 when sixty people died and many cattle were killed, and the Donora disaster in the U.S.A., when twenty people died and half the population of 14,000 was made ill. Both of these disasters were far from home and evinced little local interest.

Then, in December 1952, we had the London "smog" disaster which in a single week killed 4,000 persons, and caused an untold amount of illness. The cause was well understood. Some 200–500 ft. above the ground was a stationary layer of warm air below which was trapped a shallow layer of cold air polluted from tens of thousands of chimneys—domestic and factory ("temperature inversion"). The deaths were due to respiratory disorders and concomitant cardiac failure. All age groups were affected but more particularly those over the age of forty-five years. But it was not just a case of old people dying who were going to die shortly anyhow. The death curve rose with age, following a course parallel with the normal curve which showed that many people died a good deal before their time. It is strongly suspected that sulphur dioxide was the cause of much of this trouble. In the London smog disaster the atmospheric SO_2 content was between 14–50 times normal.

It is reasonable to suppose that the underlying cause of the high mortality in a smoke fog must operate continuously although in a lesser degree, on the health of urban communities. It may well swell the ranks of the 30,000 deaths a year from chronic bronchitis. Coupled with these bad effects on the respiratory tract is the deprivation of town dwellers from their quota of sunlight. It is well known, for example, that in the winter months the light in the centre of a city may be only one-half the quantity on the outskirts.

Evidence is also accumulating that coal smoke may be among the factors contributing to the increase in bronchial carcinoma. Coal smoke is known to contain benzpyrene which is carcinogenetic. Moreover, the incidence of lung cancer is higher in towns, especially the smokier towns, than in rural areas and it may be that coal and tobacco smoke have a reinforcing effect in this regard.

A Clean Air Bill is now before Parliament and there is little doubt that many of its provisions relating to pollution from domestic and industrial chimneys will be enforceable by the Local Authorities' Inspectorate. Progress may be impeded if the Government allow too many escape clauses in the Bill, by the shortage of smokeless fuel and by the shortage of skilled inspectors. Given the will to succeed and continuing education of the public we shall see considerable progress in this next ten years.

Tonight, I have tried to give you an idea of some of the present-day trends in the public health world. Time has not permitted consideration of other interesting developments—in services for the aged and the handicapped, of the progress being made in health education or in the prevention of tuberculosis.

I hope, Mr. President, that after listening to me tonight some of you will be able to agree with what Sir Geoffrey Vickers said in his address at the opening of the session of University College Hospital Medical School in 1954:

> ". . . when I hear people say that public health has ceased to be a live and expanding field—and even doctors have been heard to say this—I wonder whether their idea of preventive medicine is as modern as it might be."

Some of you may have been thinking that our range of activities is too wide—even to the extent of encroaching on territory which you might not consider traditional or orthodox public health ground.

I would remind you, however, that the duties of the Medical Officer of Health as laid down in the Sanitary Officers (Outside London) Regulations 1935 are that:

> "The Medical Officer of Health shall inform himself, as far as practicable, respecting all matters affecting or likely to affect the public health in the district, and be prepared to advise the Local Authority on any such matter."

With this "brief" behind him and the provisions of Section 28 of the National Health Service Act opening up unlimited possibilities of developing preventive health services I think the future of public health is by no means so gloomy as some have believed. Ira Hiscock has said that "public health is a purchasable commodity" and I look forward to the day when governments will be more willing to purchase it.

DOMENIQUE JEAN LARREY, 1766–1842

BY

A. E. S. ROBERTS

There is in the Medical Library a small seventeen-page treatise entitled *Mémoire sur l'ophthalmie regnante en Egypte, Par le Citoyen Larrey, Chirurgien en Chef de L'Armée d'Orient, 1802*. It was written and published during the short period the French were in occupation of Egypt. This historic pamphlet on ophthalmia describes a disease which is mentioned in the Ebers Papyrus but which remained unnoticed until Larrey saw it some 3,000-odd years later. He seems to have been the first to point out the contagious nature of this disease, and it is this observation which establishes the historical importance of this little work. But what makes this particular copy more interesting is that it bears the signature of Larrey and that in addition he has written on the blank last page "Les oiseaux et les animaux domestiques vient sujects à cette maladie."

Domenique Jean Larrey (1766–1842) stands alone as the greatest military surgeon in history. He was born during the most degraded, degenerated, corrupt and miserable period of modern French history in a small village in the Pyrenees, and after studying at Toulouse and Paris he eventually joined the Army of the Rhine at Strasbourg as surgeon. He later became chief surgeon to the Army in Italy and Napoleon gave him *carte blanche* in the organization of the medical division. He was with Napoleon at all his battles, and on his return to Paris from Egypt in 1801 honours were showered upon him. During the pauses between campaigns he gave courses of lectures and demonstrations and opened military medical schools in France, Spain and Germany. It is probably due to Larrey's constant work, both in teaching and organizing, that the French Army surgeons were the best in the world at this time. After the fall of Napoleon Larrey was stripped of his honours, wealth and position and barely escaped with his life. He was asked by Alexander to go to Russia to organize the medical department of his army, and Don Pedro did his utmost to induce him to emigrate to Brazil. However, in 1818 honours came again to him and he was restored to his old position in the Army, and when in 1826 he visited England, the country's greatest men vied with one another to do him homage. He was invited to Belgium by the king of that country to advise on army hospitals, and in 1834 he toured southern France and Italy. He died of pneumonia on his way home from Algiers where he had been sent to investigate some trouble which had broken out among the conscripts.

Had he done nothing more than devise the "flying ambulance" his would have been one of the illustrious names in military surgery. The old cumbersome vehicles, which required forty horses to move one of them, and owing to their size were required to remain three miles behind the firing line, were replaced by light vehicles which could go within one hundred feet of the firing line even during action and which could immediately transport the wounded to the hospitals. At Austerlitz, the bloodiest of Napoleon's conflicts, all the wounded, friend and foe alike, were operated upon, their wounds dressed, and in the hospitals in less than twenty-four hours. Larrey's treatment of the wounded was radical and diametrically opposed to precedent, and while primary amputation did not originate with him, he was the first European military surgeon to advocate the method. Amputation immediately after the injury originated with English naval surgeons in the seventeenth century, and is first plainly described by Wiseman in 1676. Immediate amputation became the general practice in the British Navy during the eighteenth century. But this was not the case with military surgeons, especially in France. Except for Le Dran, all important French surgeons recommended

delay. Fully 75 per cent. of the immediate amputations performed by Larrey and his aides recovered, an astonishing figure when it is recalled that this included all causes of death. His treatment of burns by forced feeding and stimulation excited the ridicule and opprobrium of contemporary surgeons who advocated bleeding and a greatly reduced diet. But Larrey's burn patients continued to improve. Cleanliness, simplicity and rest were his trinity of treatment. The most important of his achievements may be summed up as follows:

1. Use of salt solution in simple wounds and of Labarraque's solution in cases of infection.
2. Avoidance of all greases, ointments or elaborate dressings.
3. Avoidance of all meddlesome surgery.
4. Insistence upon rest for all wounds by not too frequent dressings.
5. Resection of ribs for empyema.
6. Supportive treatment for burns.
7. Immediate amputations.
8. Resection in selected cases.
9. Removal of sick and wounded to a base hospital as soon as possible.
10. "*Ambulances volantes*".

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"EUNUCHS DO NOT TAKE THE GOUT"

BY

G. D. KERSLEY, T.D., M.D., F.R.C.P.

Throughout the ages gout has always been linked with sex and drink. The disease is certainly becoming rare—are we not the men we were?

Gout has been described by Warner as the "dominus morborum et morbus dominorum"—the disease of the erudite and the greatest of all diseases.

Williams Cadogan commences his fifteenth-century essay on gout with the remark that "to enjoy good health is better than to command the world". He then goes on to give the background of gout, "If I am not mistaken the laudible qualities, which are at present the most in fashion, are keeping mistresses, debauching friends' wives, cheating at the gaming tables and at Newmarket, indulging in every excess and refinement in eating and drinking and speaking in Parliament."

Garrod, two hundred years later, dates gout back to antiquity, from the time when man first indulged in luxury.

The link with learning and leadership has long been recognized and may be typified by Harvey, Linné, Widal, Newton, Leibniz, Wallerstein, the two Pitts and Fox. Sir Thomas Sydenham, sometimes described as the modern Hippocrates of Medicine, writing in the seventeenth century, remarks that "gout rarely attacks fools", but adds modestly "those who chose may except the present writer". With regard to alcohol, he was lenient—"drink wine, have the gout—drink no wine and have the gout" and adds "I count water by itself crude and injurious". In those days he was certainly right.

Gout has always been considered a difficult disease to cure and there is an old Spanish proverb "with aspect to the gout, the Physician is but a lout". But did not Rousseau proclaim the need for "more perfect physics, more honest physicians, more enlightened statesmen and wiser mankind"? Lucien wrote a burlesque tragedy on the powers of the Goddess Podegra and the inefficiency of treatment.

Some of the treatments were fantastic—Walpole recommended the wearing of the "Bootikins" and goes on to say "the physicians and apothecaries who began by recommending them, now finding them specific cry them down". Yet a Bishop of Chichester was sanctified as St. Richard for lending his boots to be placed on the feet of the poor to cure the gout.

Horace Walpole had little use for Spas: "Bath is excellent for those in travail for the gout, but I certainly have no occasion to accelerate the attacks." This raises the question of precipitation of an attack by hydrotherapy which was often advised by the older physicians, even twenty years ago, as being most laudible. I never knew whether this was really to avoid the wrath of a patient who developed an acute attack during treatment.

Goethe states that to beguile the tedium of spa treatment he always engaged in some new love affair, but we know now that the excitement of stress of coitus will provoke an attack of gout.

The connexion of sex and gout certainly dates back to antiquity. Hippocrates wrote: "Eunuchs do not take gout or become bald, a woman does not take gout unless her menses be stopped, a young man does not take gout unless he indulges in coition."

Walpole, however, adopts the attitude "its an ill wind which blows no one good". "Since I must grow old and have the gout, I have long turned those disadvantages to my account and plead them to the utmost when they will save me from anything I dislike."

The term gout seems to be derived from the word gutta used by Archimataeus in the twelfth century—"gutta or gout occurs in various parts of the body, but chiefly in the joints. . . . The disease is called gout because it is caused by rheumy humours that flow drop by drop to the parts mentioned."

Now let us turn to the classification of abarticular gout. Sir Richard Blackmore in 1735 divides gout in three ways (1) hereditary or contingent, (2) "perfect", when there is an acute attack with expulsion of the impure particles into the joints and tophi, or "imperfect" when impurities are left behind and travel to other organs and (3) simple or mixed when complicated by other conditions such as stone.

Professor Palmier in 1769 includes under gout in his *Traité methodique et dogmatique de la Goutte* syphilitic gout, tumours, contusions, haemorrhoids, menstrual irregularities and almost any other disease one can conceive.

Sir Archibald Garrod, in 1876, expresses the classification of his day—accepted until fairly recently by many into (1) regular gout, (2) retrocedent or metastatic gout, suddenly flying to the stomach, intestine, heart or head, (3) abarticular gout of the digestive tract, heart or respiratory, urinary or ophthalmic system, and (4) diseases to which gouty patients are prone—gravel and calculus, sciatica and lumbago, phlebitis, kidney disease, diabetes, plumbism and pyaemia. He, however, for the first time stresses the importance of excess uric acid in the blood and crystals in the tissues in diagnosis. He also describes very beautifully the histology of the kidneys in gout. Wollaston had, however, previously, in 1797, noted uric acid in tophi.

Scudamore, 1819, explains further the theory of retrocedent gout—"when during the existence of gouty inflammation in either its acute or chronic form, a sudden cessation of the external action takes place, it sometimes happens that an internal organ becomes immediately and violently affected. The most common symptoms are acute abdominal pains and sickness or enteritis or sometimes apoplexy. Danger is pressing and, unless relief be speedily rendered, death soon closes the scene".

Alternation of visceral symptoms in gout is frequently stressed. Walpole writes "a cough is vexatious, but in old persons is a great preservative. It is one of the forms in which gout appears, and exercises and clears the lungs." He goes on "if it is content to act the personage of a cough, pray humour it, it will prolong your life if you do not contradict it and fling it somewhere else." He also states that Lord Buckingham killed himself by curing the gout with a cold application to the foot and causing an apoplexy. Even the great Trousseau said in one of his lectures "Gentlemen, ought we to treat the gout? . . . When I see a patient in an acute attack I cross my arms and do nothing—absolutely nothing."

Alternation of attacks of gout and depression are noted in the younger Pitt and suggest a psychosomatic or allergic element. Renal calculus and gout have long been connected together. Erasmus writes: "Thou hast the gravel and I the gout—we have married two sisters."

This is a little of the folk-lore attached to gout but frequently in ancient saws lurk grains of wisdom.

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ISLET CELL TUMOUR OF THE PANCREAS

(A Clinical Pathological Conference of the University of Bristol Medical School.)

CHAIRMAN: PROFESSOR T. F. HEWER

Dr. A. D. McInnes: This is the case of a young housewife aged 25, admitted under the care of Dr. Birrell on the 19th August, 1955, in an unconscious state. The history obtained from the husband was that of a 2½-year history of attacks of unconsciousness. At the beginning of her illness, in February 1953, she did not actually lose consciousness but behaved in a peculiar manner for up to two hours, for which period she had complete amnesia. After a few weeks she began to lose consciousness in the attacks and they lasted up to five or six hours. They occurred at no particular time of the day and no conducive circumstances were mentioned by the husband.

She was seen at an institute in April 1953 and a diagnosis of idiopathic epilepsy was made. An abnormal E.E.G. was noted. Anti-convulsive treatment was begun. The attacks continued despite treatment with epanutin, and luminal was added without much effect.

She was admitted to the Bristol Royal Infirmary on 10th February, 1954, at 11 p.m., having been in coma since 4 p.m. that day. She slowly regained consciousness spontaneously, was discharged the following day with a diagnosis of post-epileptic stupor and was referred to the Institute where she was receiving treatment.

These attacks increased in frequency to such an extent that termination of a three months' pregnancy was advised by the Institute and hysterotomy was accordingly carried out in March 1954. Thereafter her attacks occurred only once every second month until August 1954 when the frequency increased and epanutin was changed to hydantil.

She was finally admitted to the Bristol Royal Infirmary at 9 p.m. on 19th April, 1955, having been unconscious for 24 hours. On admission her temperature was 103° F., all limbs were flaccid but moved in response to painful stimuli, the plantars were both flexor and fundi normal. No diagnosis was made at that stage and the patient was started on penicillin. The following morning tachycardia and pyrexia persisted. Respirations slightly increased and her skin was hot and dry. She no longer responded to painful stimuli; the left plantar response was extensor and the right equivocal; the right pupil was slightly larger than the left, but pupil reactions were normal; the fundi were normal. Although there was no clinical evidence of increased intracranial pressure, in view of the bizarre story of epilepsy it was considered she might have psychomotor epilepsy as the result of a space-occupying lesion in the right temporal lobe. A neurosurgical opinion was therefore sought and she was seen by Mr. Alexander that afternoon. He described the patient as barely rousable but able to move her limbs in response to painful stimuli, the left more than the right. There was a left plantar extensor, the right probably so. The fundi were normal. 40 c.c. of 50 per cent. dextrose were administered by Mr. Alexander intravenously "with only a fleeting lightening of stupor". It was concluded that acute hydrocephalus and hypoglycaemia had been excluded. Lumbar puncture was recommended and performed with normal results of pressure, protein and cells.

She was seen later that evening by Dr. Crow who considered that spontaneous hypoglycaemia was still a possibility but did not press for an immediate blood-sugar. When this was done the following morning it was found to be 10 mg. per cent. Hence the cause of her coma was revealed and with it the probability that her whole illness

was due to a pancreatic islet cell tumour. She was given 150 c.c. of 50 per cent. dextrose intravenously and then 700 c.c. of 10 per cent. dextrose drip in 2½ hours. After this the blood-sugar did reach 210 mg. per cent. Despite this there was no change in the patient's condition. Respirations became irregular; the blood-pressure fell; she became pulseless. She was put in a respirator but she did not recover. A diagnosis of pancreatic islet cell tumour was made before she died.

Mr. G. L. Alexander: I was called in because of the unconsciousness and something of a neurological history. As far as I could work out from the glucose given (40 c.c. of 50 per cent). This would raise the blood-sugar 17 mg. per cent. and this would leave her with only 27 mg. per cent. which would still be low. The lesson that I have learnt is that a large dose of glucose must be given in these cases. I hesitated to call out the lab. on Saturday afternoon. There is some doubt whether even if this treatment had been given on admission she would have recovered. The brain sometimes appears to be intolerant of low blood-sugar leading to—no, not coma, but—heavy stupor. In other cases unconsciousness can last 48 hours or more and spontaneous recovery still occur. Some cerebra can tolerate low blood-sugar for a considerable time.

Student: Had the attacks any relationship to food, from the clinical history?

Dr. A. D. McInnes: The husband was a very accurate observer, making a careful note of the times and length of attacks. They were very rarely in the morning, only one had occurred before breakfast. They were mostly between 3 and 5 o'clock in the afternoon.

Professor T. F. Hewer: At what age did the first attack occur?

Dr. A. D. McInnes: The first attack was in February 1953.

Professor T. F. Hewer: She was then 22 or 23, and never before classed as epileptic, which is very atypical of idiopathic epilepsy. Let us have the post-mortem before we go any further.

Dr. R. L. Bishton (pathologist): Yes this was a case of an islet cell tumour. A young woman externally apparently healthy apart from a hysterotomy scar and a purpuric rash in the axilla. There was collapse of the lungs. I had fortunately heard the history of low blood-sugar so I went straight to the pancreas. I sliced through the pancreas. There was a hard nodule there, not difficult to find, 6 inches from the duodenum, whitish pink in colour. Histologically it had a rather acinar appearance but was certainly islet cell tissue.

Several conditions can give a picture of hyperinsulinism. It is all right to diagnose it and then ask the surgeon to look. Sometimes there are multiple adenomata; sometimes the tumour is very easy to feel because of a lot of fibrous tissue; sometimes there is just a hyperplasia of the islets and sometimes the tumour can be of the same consistency as the rest of the pancreas. Sometimes the pathologist is at a loss, as in the case of a young boy who was a patient of Professor Milnes Walker. I could find nothing but the boy recovered after operation so it must have been there. Here the surgeons would have been lucky had she been seen much earlier. It is possible to have adenomata of the pancreas with or without hypoglycaemia. The islet cell tissue is derived by a budding-out process from the rest of the pancreas, and finally produces insulin. I read a recent article in the *Journal of Pathology and Bacteriology* on adenoma of the pancreas (Spencer H. (1955) *J. Path. and Bact.*, **69**, 250). Some adenomata secrete insulin. Some differentiate and others do not. Some are palpable. This one was easily palpable. The brain showed a little oedema.

Professor T. F. Hewer: Perhaps Mr. Alexander would like to say a word?

Mr. G. L. Alexander: I do not know what to say about this. This is the second case of islet cell adenoma that has come our way previously diagnosed as epilepsy, both on the grounds of electroendephalography. There are lots of nice machines nowadays which do not give a straight answer. Some epileptics have epilepsy and give no abnormal pattern while others give an abnormal pattern and do not exhibit epilepsy. I am a bit of an iconoclast about these instruments. They are an extremely useful guide to the presence of an abscess or tumour of the frontal lobe, and a guide to treatment for

combination of symptoms. I always judge by the fit. The E.E.G. is just confirmatory evidence; the fit is the much more telling bit of evidence.

Dr. R. L. Bishton: There was an interesting case of a dancing instructor frequently in trouble with the police for supposed drunkenness. Fortunately he was spotted, and his illness was found to be due to hypoglycaemia. He is now all right.

Dr. E. J. Field: Was there any evidence of pituitary change?

Dr. R. L. Bishton: I did not note this microscopically.

Professor T. F. Hewer: Would Dr. Norman describe the changes in the brain for us?

Dr. R. M. Norman: The distribution of the cerebral changes in hypoglycaemia are much the same as in anoxic conditions. In severe cases there may be widespread necrosis of nerve cells in the cerebral cortex, often in a roughly laminar pattern. The cornu Ammonis, especially its Sommer sector, is particularly vulnerable and the corpus striatum and cerebellar cortex are also favoured sites for severe destruction. In some cases a selective degeneration of the granular layer of the cerebellum has been reported but usually it is the Purkinje cells which suffer most. In one case of islet cell hyperplasia described a few years ago there was a marked reduction in the number of anterior horn cells in the spinal cord in addition to the more usual findings. There had been conspicuous muscle wasting in the hands and feet. Although these cerebral changes may be aggravated by the effects of the convulsions or of circulatory failure it is generally agreed that they are essentially due to deprivation of glucose. It is therefore not surprising that there is a close resemblance to what is found in anoxia. It is quite possible for acute nerve cell changes to occur in a few hours. The cells lose their Nissl bodies, the cytoplasm stains pink with eosin and the nucleus becomes triangular and pyknotic. This co-called "ischaemic nerve cell change" is common in anoxic conditions and similar changes occur after hypoglycaemia, though the nucleus may be more obviously damaged. This ischaemic cell degeneration has been known to appear within half an hour in a man who committed suicide by hanging.

Question: Do these changes occur in about 48 hours with hypoglycaemia?

Dr. R. M. Norman: Yes, but I do not know whether they can come on so quickly as in anoxia.

Dr. B. E. McConnell: The interpretation of these E. E. G. changes seems to have had far-reaching implications. I have several epileptics in my own practice, and two at least have had children. There is one who is pregnant. She has been seen by every psychiatrist in Bristol. She is, I think, the only person to be banned from Barrow Mental Hospital for bad behaviour! She is also an hysteric. She threw a fit one Sunday evening at a prayer meeting and I was called to take her away. This I did quite simply by telephoning the St. John Ambulance. The driver asked me the name of the patient and when I told him he said, "Oh no, not her!"

With one year's history of epilepsy what were the indications for hysterotomy?

Dr. A. D. McInnes: It was on the neurologist's decision that it was terminated.

Dr. J. A. Cosh: Damage done to the brain by hypoglycaemia and by anoxia is sometimes reversible. I remember two examples: The first was a very carefree character, a diabetic, who took his insulin one morning without eating breakfast and then while he was driving in Somerset he felt dizzy and ill. He managed to stop the car, struggled out, gave himself more insulin and collapsed. He was picked up by an ambulance and sent to the B.R.I. We gave him intravenous glucose and a good meal in Casualty, and returned him home later in the day when he had recovered. Whereupon he was immediately returned to hospital with an irate note from his doctor asking was this how we treated hypogloycaemics in Bristol. He was in a dazed, stuporose condition, in spite of intravenous glucose and it took 4 days to get him back to normal although he had a raised blood-sugar and was passing sugar in his urine during this time.

Professor T. F. Hewer: He was quite all right afterwards?

Dr. J. A. Cosh: Yes. The other was an example of cerebral anoxia. She had mitral stenosis and auricular fibrillation and was to have her teeth out. She went to the theatre. As the endotracheal tube was being passed, before she was deeply under the anaesthetic, her heart stopped beating for 5–6 minutes. An abdominal incision was made for cardiac massage when her heart started beating again, now in a normal rhythm. When she came round from what anaesthesia she had had she was in a dazed, disorientated conditions for three days before she returned to normal and she appeared to have loss of memory for that period.

Student: Following this did her heart go on beating in a normal rhythm?

Dr. J. A. Cosh: No; she developed auricular fibrillation again.

Obituary

Arthur Harold Gale died on 12th October at the age of 55. He had been in poor health for months, with several periods in hospital.

He qualified from U.C.H. in 1926; he gained the D.P.H. in 1930 and M.D. Oxon., in 1933. In 1944 his Milroy Lectures at the Royal College of Physicians were entitled "A century of changes in the mortality and incidence of the principal infections which cause death or disability in childhood". Before he came to Bristol Dr. Gale was a senior medical officer in the Ministry of Health and medical officer in the Ministry of Education. In 1950 he was appointed Director of Postgraduate Medical Studies at the University and organized the popular series of Sunday lectures for family doctors.

Much of his work was unobtrusive and little recognized; for example, few realize that it was Gale who edited the *Guide to Antibiotics*, a booklet that was published by the Bristol Royal Infirmary and received a lauditory annotation in the *Lancet*. His scholarly and restrained outlook is reflected in his published researches into epidemiology.

As Assistant Editor of this journal, Dr. Gale saw into print all the facts and details in Notes and News; he undertook much sub-editing and added his own contributions in annotations and original articles.

He was a gentle and kind man and he will be sadly missed by many.

E. R. H. writes:

In the hurry and bustle of post-war life one still occasionally meets the man who makes time to put aside his own work to help others, to recognize and discuss their problems without the feeling that there is something more pressing deserving his attention.

Such an individual was Arthur Gale. Nothing was too much trouble to him if it would help another on his way.

His all-too-infrequent visits were a delight to the household, particularly the children, into whose life he was fully admitted.

Perhaps what we remember most was his courage. Fully aware of the seriousness of his illness, he continued to make light of it to the last and refused to allow consideration of his health to interfere with his duties.

Notes and News

Dr. R. Woolmer gave the Frederic Hewitt Lecture on Artistry and Science in Anaesthesia at the annual meeting of the Association of Anaesthetists of Great Britain and Ireland, held at the Royal College of Surgeons of England 1st and 2nd November, 1956.

Mr. G. J. Hadfield has been appointed Senior Lecturer in Surgery in the University of London at St. Bartholomew's Hospital.

Honorary Physician to the Queen for 1956–59

Professor I. G. Davies.

Dr. G. C. Kelly.

News from Societies

PROGRAMMES 1956–57 SESSION

BRISTOL MEDICO-CHIRURGICAL SOCIETY

On 10th October Dr. E. G. Brabbeer, F.F.A.R.C.S., was installed as President for the current session and gave an address on "Advances in Anaesthesia in the last thirty years".

Professor C. Bruce Perry, M.D., F.R.C.P., was elected President for the Session 1957–58.

14th Nov.: **Clinical Meeting** at Southmead Hospital.

12th Dec.: Sir Horace Evans, K.C.V.O., F.R.C.P., **"Hypertension and Artery Disease".**

9th Jan.: Professor C. Bruce Perry, M.D., F.R.C.P., **"Prevention of Acute Rheumatism".**

13th Feb.: Professor T. F. Hewer, M.D., F.R.C.P., and others, **"Clinico-Pathological Conference".**

13th Mar.: Mr. G. L. Alexander, F.R.C.S., **"Head Injuries".**

10th Apr.: Dr. J. H. Middlemiss, M.D., F.F.R., D.M.R.D., **"Diagnostic Radiology".**

8th May: Professor Sir Robert MacIntosh, D.M., F.R.C.S. (Edin.), F.F.A.R.C.S., **"Two months behind the Iron Curtain".**

B.M.A. (Bristol Division)

24th Oct., 8.30 p.m.: Professor G. Gordon Lennon, Professor of Obstetrics and Gynaecology, Southmead Hospital, **Film—Turkey and Iraq.** Senior Common Room, University of Bristol.

2nd Nov., 8 p.m.–1 a.m.: **Dance.**—Grand Spa Hotel, Clifton, Bristol 8.

23rd Jan., 1957, 8.30 p.m.: **Visit to New Council House, College Green, Bristol.** The Lord Mayor and Lady Mayoress will receive members and wives.

20th Mar., 8.30 p.m.: Dr. Doris Odlum, Consultant Psychiatrist, **"Medical Aspects of Homosexuality".** Main Physics Lecture Theatre, Royal Fort.

15th May, 8.30 p.m.: **Annual General Meeting.** Main Physics Lecture Theatre, Royal Fort.

*Summer, 1957: **Social Event**—to be arranged.

*21st June, 4 p.m.: B.M.A., **Reception for newly-qualified doctors** (Bristol University), Garden Hall, Royal Fort, Bristol.

26th June, 8.30 p.m.: **Clinical Meeting** at Bristol General Hospital.

* Provisional dates.

WEST OF ENGLAND CHILD HEALTH GROUP

12th Oct., 8.30 p.m.: A. V. Neale, Esq., M.D., F.R.C.P., D.P.H., Professor of Child Health, University of Bristol, **"Paediatrics in the Caribbean".** Department of Child Health Lecture Theatre, Children's Hospital.

8th Nov., 8.30 p.m.: J. F. Coates, Esq., M.D., M.R.C.P., Consultant Paediatrician, Musgrove Park Hospital, Taunton, **"The Child with Respiratory Allergy".** Department of Child Health Lecture Theatre, Children's Hospital.

7th Dec., 8.30 p.m.: Dr. Alice Stewart, M.A., M.D., F.R.C.P., Reader in Social Medicine, University of Oxford, **"Research into Child Health by a Department of Social Medicine".** Department of Child Health Lecture Theatre, Children's Hospital.

17th Jan., 5.30 p.m.: D. E. Milner, Esq., O.B.E., A.R.C.A., R.W.A., Principal, West of England College of Art, **"Child Art".** Department of Child Health Lecture Theatre, Children's Hospital.

21st Feb., 5.30 p.m.: J. C. Spencer, Esq., M.A., PH.D., Research Fellow in Social Studies, University of Bristol, **"Neighbourhood and Family".** Department of Child Health Lecture Theatre, Children's Hospital.

28th Mar., 8.30 p.m.: R. Lightwood, Esq., M.D., F.R.C.P., D.P.H., Director, Paediatric Unit, St. Mary's Hospital Medical School, Physician, Hospital for Sick Children, Great Ormond Street, **"The Home Care of Sick Children".** Department of Child Health Lecture Theatre, Children's Hospital.

April: Members of the Staff of the Children's Hospital, **Clinical Meeting.** Out-Patient Department, Children's Hospital.

25th May, 2.30 p.m.: **Field Visit.** Croydon Hall Special School, Watchet, Somerset.

B.M.A. (Gloucestershire Branch)

11th Oct. at Gloucester: W. J. Wilkin, Esq., F.R.C.S., Presidential Address, **"The Problem of the Varix".**
8th Nov. at Cheltenham: **Clinical Meeting.**
6th Dec. at Gloucester: Mr. G. N. Pattison, **Paper and illustrative films on an ophthalmic subject.**
10th Jan. at Cheltenham: **Symposium on research in General Practice.**
14th Feb. at Gloucester: S. A. Bond, Esq., F.R.C.S., **Paper on gynaecological subject.**
14th Mar. at Cheltenham: To be arranged.
11th April at Gloucester: **Clinical Meeting.**
9th May at Stroud: R. Merryweather, Esq., F.R.C.S., **Annual General Meeting and paper on orthopaedic subject.**
13th June at Gloucester: **Address by the President's Guest.**
The Gloucester meetings will be held at the Wheatstone Hall, Brunswick Road, Gloucester, with the exception of the clinical meeting in April which will be held at the Gloucestershire Royal Infirmary. The Cheltenham meetings will be held at Cheltenham General Hospital.

B.M.A. (West Somerset Division)

27th Oct.: **Clinical Demonstration on Cardiovascular Diseases** in Musgrove Park Hospital, Taunton.
22nd Nov.: **Annual Dinner and Dance** in the Empire Hall, County Hotel, Taunton.
6th Dec.: **Clinical Meeting** in Yeovil Hospital, Yeovil, when Dr. J. G. Howells, Department of Child Psychiatry, Ipswich, will speak on "Family Psychiatry and the G.P."
Early in April, 1957: **Dining Meeting.**

B.M.A. (Barnstaple Division)

13th Oct.: **Social evening.** Alexandra Hospital, Barnstaple.
14th Nov.: B. Moore, Esq., B.SC., M.D., **"Virus Diseases and the Virus Disease Laboratory."** N. Devon Infirmary, Barnstaple.

COSSHAM MEDICAL SOCIETY

Meetings held at Cossham Hospital, coffee at 8.45 for 9 p.m. meeting.

2nd Oct.: Dr. G. I. Culank, M.R.C.S., L.R.C.P., **"Presidential Address".**
6th Nov.: G. I. Strachan, Esq., C.B.E., HON. LL.D., M.D., F.R.C.P., F.R.C.S., F.R.C.O.G., Emeritus Professor University of Wales, **"Gynaecological Problems in General Practice".**
4th Dec.: Professor G. G. Lennon, CH.M., F.R.C.O.G., M.M.S.A., and R. E. Hemphill, M.A., M.D., D.P.M., **"Brains Trust".**
8th Jan., 1957: G. D. Roberts, Esq., Q.C., Recorder of Bristol, **"Doctor in the Witness Box".**
5th Feb.: Frank Bodman, Esq., M.D., **"Homeopathy".**
5th Mar.: Surgeon Commander W. A. Burnett, R.N., **"Modern Methods of Submarine Escape".**
2nd April: **Annual General Meeting.**

CLINICAL SOCIETY OF BATH

Meetings take place at the Royal United Hospital on the second Friday in the month at 8 p.m. Cases are shown at 8, briefly discussed at 8.30, and this is followed by the paper of the evening.

12th Oct.: Conjoint meeting with College of General Practitioners. A clinical evening.
9th Nov.: Mr. F. D. Murphy, **"Some Aspects of Peptic Ulcer".**
14th Dec.: Dr. Tovey, of South Western Region Blood Bank. (Title to be announced later.)
11th Jan., 1957: Mr. Hedley Hall, **"Scoliosis".**
8th Feb.: Dr. C. Hagenbach, **"Migraine".**
8th Mar.: **Clinical Conference.** (Details to be considered nearer the date.)
12th April: Dr. Ritchie Russell, of Oxford, **"Poliomyelitis".**

WEST PENWITH MEDICAL SOCIETY

The oldest medical society in Cornwall. Holds its meetings, unless otherwise stated, at 8.30 p.m., on the third Thursday in the month, at the West Cornwall Hospital, Penzance.
Visitors are welcomed, and should make themselves known to the Secretary, Dr. Douglas Truscott. There are no meetings in August.

1956

Sept.: Dr. S. A. Greenwood-Penny, Dr. D. R. Murley, **"Ancient Cornish Remedies".**

Oct.: **Annual Dinner.**

Nov.: H. W. Hughes, Esq., M.D., M.R.C.P., Medical Superintendent, Tehidy Sanatorium, Camborne, **"The Tuberculous Child".**

14th Dec.: Dr. D. H. Davies, Physician and Cardiologist, Bristol Royal Infirmary, **"Hypertension".**

1957

18th Jan.: Dr. J. H. Middlemiss, M.D., F.F.R., Director, Radiodiagnostic Department, Bristol Royal Infirmary. Title to be announced.

Feb.: Dr. Johnstone, D.P.H., Medical Officer of Health, West Penwith. Title to be announced.

March:

March: Dr. L. W. Hale, F.R.C.P., Consultant Physician, Redruth Miners and General Hospital. Title to be announced.

April: No Meeting. The Society combines with the B.M.A. for the B.M.A. Clinical Lecture.

May: Dr. A. M. Brunton, Deputy Director, Medical Services, Pfizer Ltd., **"Recent Work on Corticosteroids".**

June: Dr. Walker, PH.D., Physicist, Radiological Protection Service, **"Physics in Medicine".**

July: Dr. Philip Bryd, Chief Medical Officer, Associated Ethyl Co.. Title to be announced.

SOUTH SOMERSET MEDICAL CLUB

18th Oct.: **A.G.M. and Film Show.**

15th Nov.: Dr. Hugh Jolly, **"Paediatrics in General Practice".**

17th Jan.: **Annual Dinner and Dance.**

21st Feb.: Dr. Macdonald Critchley, **"The Romance of Huntingdon's Chorea".**

18th April: To be arranged.

PLYMOUTH MEDICAL SOCIETY

26th Sept., at 2.30 p.m.: **Joint Meeting with B.M.A.** Medical Rehabilitation Unit, R.A.F. Collaton Cross, by courtesy of the Commanding Officer, Group-Captain H. L. Willcox.

5th Oct., at 8.30 p.m.: Lawrence Abel, Esq., M.S., F.R.C.S., B.M.A. Lecture, **"Common Diseases of the Rectum and Anal Canal".** Freedom Fields.

19th Oct., at 8.30 p.m.: Short papers by Robert Blair, Esq., M.D., D.P.M., Paul Bramley, Esq., M.B., F.D.S., John Dawson, Esq., M.D., M.R.C.P., Ian Payne, Esq., M.B., F.R.C.S., D.O.M.S., Michael Reilly, Esq., M.S., F.R.C.S., Francis Wheeldon, Esq., M.B., F.R.C.S. Freedom Fields.

24th Oct.: **Annual Dinner and Dance.** The Dartmoor Restaurant (E. Dingle & Co.), Royal Parade.

9th Nov., at 8.30 p.m.: **Clinical Evening.** Greenbank.

23rd Nov., at 8.30 p.m.: Professor G. J. Cunningham, M.B.E., M.D., Professor of Pathology, Royal College of Surgeons. B.M.A. Lecture, **"Interesting Giants and Dwarfs in the last few Centuries".** Freedom Fields.

7th Dec., at 8.30 p.m.: **Clinical Evening.** Greenbank.

18th Jan., at 8.30 p.m.: Dr. J. H. Sheedon, F.R.C.P., **"Problems of Old Age".** Freedom Fields.

1st Feb., at 8 p.m.: **Clinical Evening** at the Royal Naval Hospital, by courtesy of Surgeon Rear-Admiral A. A. Pomfret, O.B.E., Q.H.S., R.N.

15th Feb., at 8.30 p.m.: A. Dickson Wright, Esq., M.S., F.R.C.S., **"How Patients have deceived me".** Freedom Fields.

1st Mar., at 8.30 p.m.: Professor E. P. Sharpey-Schafer, F.R.C.P. Freedom Fields.

13th Mar., at 2.30 p.m.: Visit to Dame Hannah Rogers School for Cerebral Palsy, Ivybridge.

THE DEVON AND EXETER MEDICO-CHIRURGICAL SOCIETY

4th Oct., at 8.15 p.m.: Mr. Dendy Moore, F.R.C.S., **"The use of the radio-opaque medium Diodone in surgical diagnosis and treatment".**

18th Oct., at 4 p.m.: Dr. J. W. Cook, F.R.S., Vice-Chancellor of Exeter University, **"Chemical Carcinogens and their Significance".** (South Western Dinner.)

15th Nov.: **Clinical Meeting.**

3 p.m.: Cases on view in Medical Out-Patients Department.

4 p.m.: Tea, followed by Discussion on Cases in Library.

13th Dec.: The President's Party to which wives of members are invited.

8 p.m.: The Board Room.

9 p.m.: The Library. (The Elizabethan Singers.)

17th Jan., at 8.15 p.m.: J. Lloyd Griffith, Esq., F.R.C.S., G. F. Trobridge, Esq., M.B., M.R.C.P., Anthony Daly, Esq., M.D., M.R.C.P., **Symposium on The Surgery of the Heart.**

21st Feb., at 8.15 p.m.: **Clinico-Pathological Demonstration.**
21st Mar.: **Clinical Meeting.**
3 p.m.: Cases on view in Medical Out-Patients Department.
4 p.m.: Tea, followed by Discussion on Cases in Library.
4th April, at 3 p.m.: **Clinical Meeting** at the Princess Elizabeth Orthopaedic Hospital, followed by tea.
25th April, at 8.15 p.m.: **Annual General Meeting, Clinico-Pathological Demonstration.**

TORQUAY AND DISTRICT MEDICAL SOCIETY

All meetings are on Thursdays, and at Torbay Hospital unless otherwise stated.

25th Oct., at 4 p.m.: Opening Meeting, Sir Charles Symonds, K.B.E., C.B., M.D., F.R.C.P., **"Vertigo".**
7.45 for 8.15 p.m.: Dinner and Dance at the Palace Hotel, Torquay.
8th Nov., at 8.30 p.m.: Dr. W. A. Gillespie, **"Modern Antibiotics".**
22nd Nov., at 3 p.m.: Combined Clinical Meeting with the S.W. Branch of the British Medical Association.
13th Dec., at 8.30 p.m.: Sir Heneage Ogilvie, K.B.E., M.D., M.CH., F.R.C.S., **"Medical Rackets".**
24th Jan., at 8.30 p.m.: Mr. John Peel, F.R.C.S., F.R.C.O.G., **"Some Common Gynaecological Problems in Everyday Practice".**
14th Feb., at 8.30 p.m.: Combined Clinical Discussion with the Clergy, **"Abuse of Sedation".** Victoria Hotel, Torquay.
21st Mar., at 8.30 p.m.: Mr. Lawrence Abel, F.R.C.S., **"Common Diseases of the Rectum".**
25th April, at 8.30 p.m.: Dr. Peter Bishop, M.R.C.P., **"Facts and Fancies in Clinical Endocrinology".**
30th May, at 8.30 p.m.: **Annual General Meeting.**

CORNWALL CLINICAL SOCIETY

The pattern of the evenings will be the same as before: refreshments are served from 8.0 to 8.30 and the Meeting takes place from 8.30, finishing not later than 10.30.

1st Nov.: (1) Dr. C. J. F. Coombs, **"Birds and Men: Their Behaviour and Some Comparisons";** (2) Dr. C. T. Andrews, **"The Romance of John Keats, Apothecary and Poet."** (Illustrated by lantern slides). Royal Cornwall Infirmary (Ladies' Night).
29th Nov.: **B.M.A. Dinner and Dance.**
7th Dec.: **Clinical Evening.** Camborne–Redruth Hospital.
10th Jan.: **"Any Questions".** A Medical Quiz with a Specialist Panel. Royal Cornwall Infirmary.
1st Feb.: Dr. Hugh Jolly, **"Paediatrics in Modern General Practice".** Camborne–Redruth Hospital.
7th March: **Clinical Evening.** Royal Cornwall Infirmary.
April: Sir Heneage Ogilvie, **"Diagnosis of the Jaundiced Patient".** Royal Cornwall Infirmary.
2nd May: Various Contributors, **"Personal Experiences of Illnesses and Operations".** Camborne–Redruth Hospital.
7th June: **Clinical Evening.** St. Lawrence's Hospital, Bodmin.
4th July: **Cases and Demonstrations by the Consultant Staff.** Royal Cornwall Infirmary.
3rd Oct.: **Presidential Address and Annual General Meeting.** Royal Cornwall Infirmary.

POST-GRADUATE COURSES

UNIVERSITY OF BRISTOL

The following courses are being arranged:
Week-end Course at Plymouth, 30th Nov. to 2nd Dec.
Ward-rounds at Southmead Hospital, Dec. 1956 to March 1957.
Dental Course, 8th to 13th April 1957.
Sunday morning Lecture-Demonstrations, April to June 1957.
Further details may be obtained from the Department of Post-Graduate Medical Studies.

ROYAL DEVON AND EXETER HOSPITAL

Meetings will be held at 8.30 p.m. on Tuesdays in the Library.

16th Oct.: Mr. J. E. Richardson, **"Stomachs in East London".**
23rd Oct.: Dr. N. S. Alcock, **"Neurological Emergencies".**
30th Oct.: Mr. C. C. Jeffery, **"Treatment of Fractures in the Aged".**
6th Nov.: Dr. H. R. Jolly, **"Paediatrics in Modern General Practice".**
13th Nov.: Dr. G. D. Adkins, **"Chemotherapy of Tuberculosis".**
20th Nov.: Mr. A. C. Gairdner, **"Urinary Obstruction".**
27th Nov.: Mr. G. N. Cantrell, **"Some Ophthalmic Problems".**
4th Dec.: Dr. A. J. Daly, **"Salt and Water".**
11th Dec.: Dr. M. G. Thorne, **"Uses and Dangers of Steroid Therapy".**
18th Dec.: Dr. C. M. Seward, Mr. H. D. Moore, Dr. J. O. P. Edgcumbe, Mr. D. Jefferiss, Dr. F. S. W. Brimblecombe, Dr. N. Sawers, Chairman: Dr. A. J. Daly, **Panel Discussion: "Any Questions".**

Appointments

UNITED BRISTOL HOSPITALS

June to October 1956

Name	*Appointment*	*Formerly*
McCORMICK, A. J. A., M.B., F.R.C.S., D.O.M.S.	Senior Registrar in Ophthalmology.	Registrar, U.B.H.
HEATON, J. M., M.B., B.CHIR., D.O.	Registrar in Ophthalmology.	Registrar, Oxford Eye Hospital.
EVE, N. H., M.B., B.S., D.A.	Registrar in Anaesthetics.	S.H.O., U.B.H.
CLARKE, A. D., M.B., CH.B., F.F.A.R.C.S., D.A.	Registrar in Anaesthetics.	S.H.O., Southmead Hospital.
ISAACSON, A. H., M.A., M.D., M.R.C.P., B.CH.	Registrar in Radiodiagnosis.	Part-time.
DOYLE, F. H., B.SC., M.B., CH.B.	Registrar in Radiodiagnosis.	Part-time.
PATTON, MRS. IRMGARD, M.D. (GREIFSWALD), L.A.H. (DUBLIN).	Registrar in Radiodiagnosis.	H.P., Gulson Hospital.
NOBBS, MRS. MARJORIE, B.SC., M.B., CH.B., D.M.R.T.	Registrar in Radiotherapy.	S.H.O., U.B.H.
LAWRENCE, A. C. K., M.B., B.S.	Registrar in Pathology.	R.A.F. Institute of Pathology, Halton.
AYLIFFE, G. A. J., B.SC., M.B., CH.B.	Registrar in Pathology.	S.H.O. in Pathology, U.B.H.
MAWER, MISS JOAN, M.B., B.S., D.C.H.	Registrar in Paediatrics.	Registrar, South Devon and East Cornwall Hospital, Plymouth.
CAMERON, I. W., L.D.S., B.D.S.	Registrar in Dental Surgery.	S.H.O., U.B.H.
IRWIN, J. A. L., B.D.SC., L.D.S. (MELBOURNE).	Registrar in Orthodontics.	North West Metropolitan Regional Hospital Board.

SOUTH-WESTERN REGIONAL HOSPITAL BOARD

June to October 1956

BRISTOL

Name	*Appointment*	*Formerly*
MATHER, H. G. M.D. (WESTERN RESERVE), M.A., M.B., B.CHIR.(CAMB.), M.R.C.P. (LONDON), M.D. (CAMB.).	Consultant Physician, Southmead Hospital.	Senior Medical Registrar—joint appointment with S.E. Metropolitan R.H.B. and King's College Hospital.
PELMORE, J. F., M.R.C.S., L.R.C.P., D.A. (R.C.P. & S.), F.F.A.R.C.S.	Consultant Anaesthetist, Frenchay Hospital.	Consultant Anaesthetist, Tunbridge Wells Group of Hospitals.
LYON, H. F., M.B., CH.B. (EDIN.), D.T.M. (ANTWERP), M.R.C.P. (EDIN.).	Assistant Physician (Geriatrics), Manor Park Hospital, Bristol.	Medical Registrar, Falkirk Royal Infirmary.
BURNS, MARGARET E., M.B., CH.B. (B'HAM), D.C.H., D.A.	Anaesthetic Registrar, Southmead Hospital.	Registrar, Dudley Road Hospital, Birmingham.

Name	*Appointment*	*Formerly*
GUY, JOAN, B.SC. (WALES), M.B., B.CH. (WALES), D.C.H.	Registrar to the South-West Regional Blood Transfusion Centre, Southmead.	Registrar in Pathology, United Bristol Hospitals.
VALAES, T., M.B. (ATHENS), D.C.H. (ENGLAND).	Paediatric Registrar, Southmead Hospital.	Casualty Officer, Paddington Green Children's Hospital.
GREGORY, C., M.B., CH.B. (LIVERPOOL).	Registrar in Psychiatry, Bristol Mental Hospitals.	Asst. Lecturer in Physiology, University of Liverpool.
GRANT, BRENDA, M.B., CH.B. (LIVERPOOL), D.P.M. (ENGLAND) & R.C.P.S.I.).	Registrar in Psychiatry, Bristol Mental Hospitals.	S.H.O. in Psychiatry, Bristol Mental Hospitals.
WARNER, J., M.B., CH.B. (B'HAM).	Registrar in Child Psychiatry and Mental Deficiency, Bristol.	Registrar in Psychiatry, Bristol Mental Hospitals.
	NORTH GLOUCESTERSHIRE	
DOWNING, W. B. L., M.B., CH.B. (B'HAM), F.R.C.S. (EDIN.), D.L.O. (R.C.S.).	Consultant Ear, Nose and Throat Surgeon, North Gloucestershire Clinical Area.	Senior Registrar, United Birmingham Hospitals.
TOOMEY, A. G. G., B.SC., M.R.C.S., L.R.C.P., D.M.R.D.	Consultant Radiologist, North Gloucestershire Clinical Area.	Senior Registrar, North Gloucestershire Clinical Area.
WYPKEMA, W., M.B., CH.B. (PRETORIA).	Surgical Registrar, Cheltenham General Hospital.	S.H.O. in General Surgery, United Bristol Hospitals.
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DEVON AND CORNWALL

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